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Physician Ownership in Pharmacies

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NOTES

PHYSICIAN OWNERSHIP IN PHARMACIES

We fix and ordain — to prevent any pharmacist from having temptation or reason for sinning — that no pharmacist may keep shop in partnership or agreement with any physician.

— *Genoa Legal Code of 1407*

With purity and holiness I will pass my life and practice my art. . . . Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption.

— *Hippocratic Oath*

I. Introduction

In 1950, seven pharmacies served the citizens of Coffeyville, Kansas (population, 17,113). Of these, four were owned by registered pharmacists, two by local businessmen, and one was owned by a group of doctors and their wives. Today, there are nine pharmacies in Coffeyville (population approximately 17,500). Three of these are partially or completely owned by a total of seven doctors practicing in the community.¹

Druggist X, the owner of one of the original seven pharmacies in the city, earns a large part of his income by filling drug prescriptions. Doctor Y is a successful general practitioner in Coffeyville. In 1957, Druggist X filled an average of 57 prescriptions per month for Doctor Y's patients. In the following year, Doctor Y joined two other local physicians in opening their own pharmacy in the medical building they owned and occupied. Soon thereafter, the average number of Doctor Y's prescriptions filled by Druggist X fell to 29 per month, and in 1963 to only 11 per month, a drop of 81 per cent.

In contrast, in 1957 Druggist X filled an average of 41 prescriptions per month written by Doctor Z, and this rose to an average of 50 in 1958, and 77 in 1963, an increase of over 87 per cent. Doctor Z is an independent practitioner who has no interest in any pharmacy.

In cities and towns across the country, the number of pharmacies owned by physicians is slowly increasing. In Texas, for example, there were approximately 66 of these pharmacies in 1960. The number rose to 93 in 1962, and today there are approximately 117.² Physicians in California owned 39 pharmacies in 1949, 213 in 1962, and between February of 1962 and February of 1963 an additional 39 such pharmacies were registered with the state pharmacy board.³ Similarly, although there were only 5 physician-owned pharmacies in Wisconsin prior to 1950, their number increased to 12 in 1960, and 24 in

¹ These and the following statistics concerning the pharmacy business in Coffeyville, Kansas, are found in, Statement of Jack R. Issacs, *Pharmacist*, Coffeyville, Kansas, *Hearings on Physician Ownership in Pharmacies and Drug Companies Before a Subcommittee of the Senate Committee on the Judiciary*, 88th Cong., 2d Sess. 175-77 (1964) [hereinafter cited as *Hearings*].

² Statement of Joe H. Arnette, *Secretary*, Texas State Board of Pharmacy, *Hearings*, 6.

³ Statement of Benjamin J. Kingwell, *President*, California Pharmaceutical Ass'n, *Hearings*, 163.

1964.⁴ In the latter state, all but one of these pharmacies are found in communities which have pharmaceutical services available through other licensed pharmacies.⁵

Although these figures represent a small percentage of the total number of pharmacies in these states they do indicate a trend which could create serious problems for the nation's independent druggists. Several states have been sufficiently alarmed by this possibility to pass recent legislation prohibiting or regulating physician ownership of pharmacies.⁶ The problem also became important enough to attract the attention of the Senate Subcommittee on Antitrust and Monopoly. In August of 1964, hearings were held to consider the possible antitrust implications of doctor-owned pharmacies and the similar problem of physician ownership in drug companies. This note will consider only the former problem of physician-owned pharmacies.

A brief history of the growth and decline of pharmacy as a profession serves as a good starting point for the discussion. In the early days of the practice of the healing arts in this country, men looked to the physician not only to diagnose and treat their ills, but to dispense necessary medication as well. Pharmacists were still few in number and unrecognized as a professional group. As pharmacy grew in stature, schools of pharmacy were established, the number of trained pharmacists increased, and pharmacy was able to offer its services to the physician and to the public on a wider scale. At a time when most drugs had to be compounded, the physician found it to his benefit to turn over this time-consuming task to the local pharmacist, thereby also eliminating his costly inventory of drugs. It was recognized that the public was best served if the responsibility for diagnosing and treating the disease fell exclusively to the physician, and that of preparing, compounding and dispensing the medication was left to the pharmacist. At an early date it was also recognized that it was consonant with the trust and confidence reposed in each by the community that they operate independently and fee splitting between the two practitioners was prohibited.⁷

Although pharmacy was considered a profession by some, it never attained the status enjoyed by the attorney or the physician. Unlike these professionals, a pharmacist could be hired, and his services sold to the public. As the preparation and compounding of drugs moved from the apothecary shop to the factory, and the pharmacist introduced ice cream, magazines, and greeting cards into his inventory, he lost a great deal of his professional distinction and came to be thought of as more of a businessman than a professional. Although many state

⁴ Statement of Paul A. Pumpian, *Secretary*, Wisconsin State Board of Pharmacy, *Hearings*, 211.

⁵ *Id.* at 204.

⁶ CAL. BUS. & PROF. CODE § 654; MD. ANN. CODE art. 43, § 266A(c)(4) (iii) (Supp. 1964); N.D. CENT. CODE 43-15-35(5) (Supp. 1965); PA. STAT. ANN. tit. 63 § 390-5(9) (xii) (Supp. 1964). Michigan is apparently the only state which requires ownership of pharmacies by pharmacists. MICH. STAT. ANN. § 14.771 (1956). This law was first enacted in 1929.

⁷ Statement of Dr. William S. Apple, *Executive Director*, American Pharmaceutical Ass'n, *Hearings*, 187. Although the majority of the pharmacies in the United States in 1852 were physician-owned, this apparently was not looked upon as fee splitting. *Id.* at 195.

statutes declared pharmacy to be a profession and provided that the license of a pharmacist could be revoked for unprofessional conduct,⁸ many others looked upon it as more of a trade and regarded the pharmacist as little more than a pill salesman.

Due in part to the uncertainty of the professional status of the pharmacist, complete separation between the pharmacist and the physician never became a reality. Pharmacy never became a true profession, and never attained the station enjoyed by medicine. Indicative of this is the fact that it is considered permissible for the physician to dispense drugs in his office to his own patients. Since this practice is not viewed as an invasion of a different professional field, no limitations are placed upon the types or quantities of drugs the physician may dispense in this manner, and the pharmacist thereby loses a fair percentage of the prescription market.⁹

As the drug market expanded, and profits became greater,¹⁰ it was only natural for some physicians to look to pharmacy as a profitable investment. Since they dealt with drugs and knew their prices and ingredients, they understood a great deal about pharmacy and the business of running a drugstore. By purchasing an establishment, and hiring a registered pharmacist to manage the business and dispense the drugs, these physicians could reap the profits of drug sales without undergoing the inconveniences and disadvantages of storing drugs in their own offices. As more and more physicians invested in pharmacies, and some unscrupulous doctors contrived methods to channel their own prescriptions to the pharmacies that they owned,¹¹ the independent pharmacist realized that his livelihood was being threatened by forces which were beyond his control. It was this realization which brought the attention of the two professions and the federal government to focus on the problem.

8 *E.g.*, MINN. STAT. ANN. § 151.06(6) (e) (Supp. 1964); N.Y. EDUC. LAW § 6804.

9 In 1929, pharmacies dispensed 74% of the wholesale value of prescription drugs while hospitals and dispensaries accounted for 13%. An additional 13% was dispensed by doctors. In 1956, pharmacies accounted for only 56% of the value of total sales, while 24% were attributable to hospitals and 20% to physicians. SOMERS & SOMERS, DOCTORS, PATIENTS, AND HEALTH INSURANCE 94 (1961); KRAMER, *Drugs and Medicines*, PUBLIC HEALTH REPORTS 932 (1958).

10 In 1929, retail prescription sales were \$140 million, while in 1956 they rose to \$1.5 billion, an increase of almost 1,000%. Prescriptions rose from approximately 10% of total drugstore sales to about one third. KRAMER, *supra* note 9, at 932.

In 1958 the 53,000 retail pharmacists in the United States filled 655,550,000 prescriptions—about 56 percent of which were new prescriptions, and the balance, refills. In 1959, they filled 711,660,000—an increase of nearly 9 percent, while the population rose less than 2 percent.

The number of prescriptions per family has jumped from 8 per year in 1954 to more than 11 in 1959, and the average annual expenditure per family for prescriptions has soared from \$20 to \$32.50 in the same 6-year period. In the 10-year period, 1949 to 1959, the annual number of prescriptions per doctor jumped from about 1,700 to more than 2,500.

Prescribed drugs are now one of the most significant items in the cost of medical care, accounting for \$1 out of every \$5 spent for medical services. "The Consumer's Stake in Drugs," Office of Research, Nationwide Ins. Co., Columbus, Ohio, *Hearings*, 266.

11 See text accompanying notes 16-19 *infra*.

II. Economic and Ethical Aspects of Physician-Owned Pharmacies

A. *The Economic Problem*

There are commonly three types of physician-owned pharmacies: (a) a pharmacy completely or partially owned by the physician and registered in his or his partner's name; (b) a pharmacy where control and ownership is vested in the doctor's immediate family; (c) a pharmacy owned by physicians engaged in a group practice wherein space is leased to the pharmacist at a very high rent or with a percentage lease. All of these forms of ownership create situations in which it is tempting to the physician to in some way influence his patient to have his prescription filled at the pharmacy in which he has an interest. Although today's pharmacist has turned to the sale of many items besides drugs to supplement his income, the profit on drugs is still high,¹² and a large percentage of the pharmacist's income depends on the number of prescriptions he fills each year. So long as the buyer is able to exercise his free choice as to which pharmacy he will patronize,¹³ the independent druggist's prescription sales will remain fairly constant and he will be able to compete with doctor-owned pharmacies on a more or less equal basis. However, if the free choice of the patient is interfered with, and he is steered to a certain pharmacy by the doctor who writes the prescription, the independent druggist suffers.

The greatest threat to the independent druggist is undoubtedly the clinic-owned pharmacy. Today, it is not unusual to find medical clinics of various sizes in even the smallest of communities. In large cities, clinics with as many as thirty doctors are not uncommon. Like the modern shopping plaza, the medical clinic is a great convenience to the patient because it enables him to obtain most of his medical services under one roof. When a clinic is established in a certain locale, the prescription business which results can be a great boon to local pharmacies. However, if the clinic also has its own pharmacy, it cuts sharply into the trade of the local pharmacist, much as the plaza supermarket injures the independent corner grocer.

However, a distinction must be made between clinic pharmacies in which the pharmacist leases space at a reasonable yearly rental, and those in which the pharmacist is merely an employee of a group of physicians or leases space at a very high yearly rental or a percentage of the gross.¹⁴ In the former instance, the physicians have nothing to gain by steering their patients to the clinical pharmacy, and the free choice of the patients is usually not interfered with, and the local pharmacy can still compete with the clinic pharmacy albeit the latter has the better location. In the latter situation however, the physician

12 "For example, on 25 mg. chlorpromazine tablets, the price to the druggist in 1959 was \$3.03, the price to the consumer \$5.05; on prochlorperazine, the prices were respectively, \$3.93 and \$6.55." TALALAY, *DRUGS IN OUR SOCIETY* 177 (1964).

13 In 1963, the Judicial Council of the American Medical Association stated that the patient is entitled to a copy of his prescription and has the right to have it filled wherever he wishes. AMERICAN MEDICAL ASSOCIATION, *JUDICIAL COUNCIL OPINIONS AND REPORTS* 6 (1964). [Hereinafter cited AMA COUNCIL REPORTS.]

14 The lease of a pharmacy based on a percentage of the profits has been declared unethical by the American Medical Association. *Id.* at 50.

stands to profit by directing his patients to the pharmacy, and there is the possibility that the local pharmacists' business will be injured.

To a certain extent, both physicians and pharmacists have a monopoly over the prescription trade by virtue of their licenses to practice. Ethical drugs may be purchased only with a doctor's prescription and only a registered pharmacist may fill that prescription.¹⁵ To a certain extent, the patient is a captive consumer. The doctor dictates what brand the patient must buy, and the pharmacist is forbidden by law to substitute a different brand, even though it is equal in quality or can be obtained at a cheaper price.¹⁶ Similarly, the doctor orders the amount of drugs and also prescribes in what quantities the medication must be consumed. Demand is exercised by he who orders and does not pay, rather than by he who pays and consumes. The physician is able to exercise this extraordinary control because the patient fully realizes that he disobeys the doctor's orders at the risk of his health. "There is, in fact, no other product or service necessary to the maintenance of life that so completely escapes the exercise of consumer sovereignty as does the prescription drug in the circumstances under which it is sold today."¹⁷

Practically speaking, the only economic freedom the patient has is to determine the pharmacy at which he will purchase his medication, and if he wishes, to shop at various pharmacies and inquire about prices before he makes his decision. When this freedom is interfered with, the buyer becomes a *totally* captive consumer. If it is the prescribing physician who exercises this final control over his patient, his monopoly becomes complete. Usually the totally captive consumer does not realize that in addition to his charge for professional services, the doctor is collecting profit from drug sales as well.

There are many methods by which the physician may interfere with the patient's free choice of pharmacies. Some of these are apparent attempts to channel the buyer's prescription to a certain pharmacy. Other methods are more subtle in influencing the patient's choice. The more notorious methods have been declared unethical by the American Medical Association or the American Pharmaceutical Association,¹⁸ but the more cunning methods thrive on. Some clearly unethical methods are:

(a) Coded prescriptions — By writing the prescription in code, the physician forces the patient to have it filled by the druggist who understands the code, and who is often the physician's employee or is splitting fees with him. This practice has been declared unethical by both the AMA and the APhA.¹⁹

(b) Direct telephone line to pharmacy — The doctor's prescription is phoned to a nearby pharmacy, and the patient is told where to pick up his medication. The AMA "looks with disfavor" upon this practice "on the theory that a patient is entitled to a written prescription which he can take to the pharmacist of his choice."²⁰

15 Ethical drugs are to be distinguished from proprietary drugs which are sold without prescriptions under brand names.

16 *E.g.*, MINN. STAT. ANN. § 151.21 (1946); N.Y. EDUC. LAW § 6804(3)(k).

17 *Rx Drugs: The Real Problem*, 25 CONSUMER REPS. 380-82 (1960).

18 Hereinafter referred to as the AMA and the APhA respectively.

19 AMA COUNCIL REPORTS, 51-52; APhA CODE OF ETHICS, para. 14.

20 AMA COUNCIL REPORTS, 52.

(c) Pneumatic tubes between doctor's office and pharmacy — Obviously, this system is employed most effectively in a clinic. With a pharmacy directly downstairs, the physician need only write the prescription or perhaps dictate it to an assistant, and then send it down to the pharmacy to be filled. In some cases the physician places the charge for drugs on his own bill. Although neither the AMA or the APhA have expressly declared this practice to be unethical, it is clear from what has been said thus far that it would be discouraged.

There are also more subtle methods by which the physician influences the patient to have his prescription filled at the doctor's pharmacy. Some are difficult to determine because they employ subtle methods of persuasion and take advantage of the doctor's great influence over the patient. Some of these more prevalent methods are:

(a) Oral communication — The doctor usually instructs the patient, "Have this filled at Doe's pharmacy down the street." Very often, the buyer will comply with the doctor's wishes.

(b) Name of the pharmacy advertised on the prescription blank — Again, the patient will very often believe that the advertised pharmacy is where the doctor would like him to fill his prescription. The Judicial Council of the AMA has said that prescription blanks should not include the name of any pharmacy.²¹

A physician-owned pharmacy usually has an economic advantage over all others. First, it does not have to stock as great an inventory of drugs as other pharmacies because the doctor-owner can limit his prescription writing to drugs which are in stock. Also, in some cases physicians may be given a professional discount when they purchase drugs while the pharmacist must pay the higher price.²² This means either that the doctor-owner can sell his drugs at a lower price, or that he can sell them at the standard price and reap a greater profit. Finally, the practicing physician receives a great deal of sample medication through the mails.²³ The unscrupulous practitioner may use these free samples to fill prescriptions in his establishment.

Both the physician who owns the drugstore and the pharmacist who co-operates with him are governed by professional codes of ethics promulgated by professional organizations which represent most of their number. They are thought to be governed by ethical standards and public responsibilities which go beyond the minimum requirements of the law. To discuss the question of physician ownership of pharmacies, it is necessary to consider not only the economic effects of such ownership, but these ethical effects as well.

²¹ Statement of Robert B. Throckmorton, *General Counsel*, American Medical Ass'n, *Hearings*, 218.

²² Statement of Paul A. Pumpian, *Secretary*, Wisconsin State Board of Pharmacy, *Hearings*, 206.

²³ *Ibid.* In 1963, the drug industry spent approximately \$225,000,000 promoting its products to the approximately 200,000 physicians in the United States — more than \$1,000 per year per each physician. TALALAY, *op. cit.* *supra* note 12, at 145.

B. *The Ethical Problem*

1. Conflicts of Professional and Commercial Interests

When a physician purchases a pharmacy whose business he can affect by his own prescription writing, a definite conflict of interest develops. The conflict arises between the physician's duty to his patient and his natural desire for financial gain. The relationship between a physician and his patients is in every sense a fiduciary one of the highest trust and confidence. For the medical practitioner, the very concept of professionalism contemplates the absence of conflict between a physician's private interests and the interests of his patient. "The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration."²⁴ Undoubtedly, the large majority of practicing physicians live up to the high standards expected of them, but, as is the case with every profession some do not, and these few lower the status of the profession precisely wherein its strength lies — the respect and confidence accorded to it by the public.

A physician who has no interest in where his prescriptions are filled may be tempted to prescribe unnecessary medicine, or to prescribe a drug which yields a greater margin of profit, or to keep the patient on drugs for an unnecessarily long period of time.

Of course, doctors resent the implication that they cannot be trusted to own a pharmacy and conduct both it and their own practices for the public welfare. The great majority of physicians have every right to be resentful. If a patient places his trust and confidence in a doctor to use his knowledge, skill, and judgment in prescribing medicines, should he also not trust the doctor not to exploit him through such prescriptions? If a common businessman has the right to own a pharmacy, should the dedicated physician be denied an equal right? These are some of the questions posed by those inside the medical profession who assert that "the mere opportunity to exploit, the opportunity for personal gain, should not in itself condemn [such ownership]."²⁵

However, often a profession will declare a certain practice unethical not because it is evil but because it creates the appearance of evil. Although some would say that appearances should never condemn, they often do. It is submitted that a doctor-owned pharmacy is precisely the type of practice which should be condemned solely because it fosters an appearance of evil and undermines the honor and dignity of the medical profession. This practice shakes the confidence of the patient in both the physician and the pharmacist and creates suspicions that they are merchandising medicine on an innocent public. It also creates doubts in the minds of the public as to the value of the professional services rendered, and the quality or quantity of medication prescribed. The layman also tends to equate this practice with fee splitting. All of these suspicions and doubts combine to injure the reputations of all physicians. To their discredit, neither the AMA nor the APhA presently condemn physician-owned pharmacies.

²⁴ AMA COUNCIL REPORTS, 3.

²⁵ Statement of Robert B. Throckmorton, *General Counsel*, American Medical Ass'n, *Hearings*, 219.

In fact, the steps which the AMA has taken in revising its code of ethics to allow this practice have only added to this appearance of evil.

2. The Principles of Medical Ethics of the American Medical Association

Among professional organizations, the AMA occupies an enviable position. Its authority and influence over medical affairs is unique among such associations. The source of its power lies in its large membership and its considerable financial backing. Since its formation in 1847, the AMA has promulgated a code of ethics to govern the conduct of its member physicians with hopes of elevating the standards of the entire profession and increasing public confidence in it. One of these principles is that "physicians should recognize and promote the practice of pharmacy as a profession. . . ."²⁶ Although in the main the AMA has lived up to this principle, it does not presently look upon physician-owned pharmacies as violative of either its letter or its spirit. This was not always the case.

Prior to 1954, section VII of the Principles of Medical Ethics provided: "An ethical physician does not engage in barter or trade in the appliances, devices, or remedies prescribed for patients, but limits the source of his professional income to professional service rendered the patient."²⁷

In 1954, apparently in response to pressures created after the state of New York discovered 187 physicians in undercover arrangements with druggists,²⁸ this section was amended to read: "It is unethical for a physician to participate in the ownership of a drugstore in his medical practice area unless adequate drugstore facilities are otherwise unavailable. . . ."²⁹ Thus, at this time the AMA took a definite stand on the issue. The practice of physician-owned pharmacies was declared unethical, with a limited exception. However, approximately one year later, the above statement was dropped, and the following was substituted: "It is not unethical for a physician to prescribe or supply drugs, remedies, or appliances as long as there is no exploitation of the patient."³⁰ This statement was again changed in 1957 to read: ". . . Drugs, remedies, or appliances may be dispensed by the physician provided it is in the best interest of the patient."³¹

In an attempt to clarify the import of this language, the judicial council of the AMA issued a statement which explained that the phrase "in the best interest of the patient" did not authorize the doctor to dispense drugs "solely

26 AMA COUNCIL REPORTS, 2.

27 Statement of Phillip F. Jehle, *Associate General Counsel*, National Ass'n of Retail Druggists [hereinafter denoted NARD], *Hearings*, 150. The subsequent textual discussion of the evolution of the AMA's pronouncements with regard to physician-owned pharmacies is documented by references to the *Hearings* as well as by references to the actual AMA statements of these ethical principles in order to give the reader the benefit of Mr. Jehle's interpretation of the evolutionary cycle.

28 CARTER, *THE DOCTOR BUSINESS*, 133 (1958).

29 Statement of Phillip F. Jehle, *Associate General Counsel*, NARD, *Hearings*, 150.

30 *Ibid.* PRINCIPLES OF MEDICAL ETHICS, ch. I, § 8 (1955).

31 Statement of Phillip F. Jehle, *Associate General Counsel*, NARD, *Hearings*, 150; PRINCIPLES OF MEDICAL ETHICS, § 7 (1964) (as found in AMA Council Reports, VII).

for his own convenience or for the purpose of supplementing his income,"³² and then continued: "It is, however, the definite opinion of the . . . judicial council that the ownership of a pharmacy . . . can, under certain conditions, become unethical and contrary to the best interest of the public and the medical profession."³³ The use of the word "however" in the above-quoted passage confuses the attempted clarification. The word implies that the council's statement that doctors may not dispense drugs for their own profit did not flatly declare this practice to be unethical although the import of the earlier language was certainly to that effect. Thus there exists an apparent contradiction in the council's "explanation."

In November of 1962, the chairman of the judicial council, Dr. George A. Woodhouse, proposed a ban against doctor ownership of pharmacies. Opposition to the proposal was vigorous and it was killed in the reference committee. When testifying about the fate of his proposal at the congressional hearings Dr. Woodhouse commented that, ". . . they really ground me up pretty fine. I looked like I had come out of a meat grinder."³⁴ In 1963 the house of delegates of the AMA concurred in a statement of the judicial council which approved physician-owned pharmacies. The council proclaimed: ". . . it cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient."³⁵ Today, section VII of the code of ethics employs the same language it used in 1957.³⁶

In attempting to regulate possible abuses of the doctor's prescription power, the AMA, as indicated above, has ruled through its judicial council that the patient is entitled to a free choice of pharmacists,³⁷ and also to a copy of his prescription.³⁸ It is assumed that if the physician-owner lives up to the council's directives and to the code of ethics, the patient's free choice will not be interfered with. This is undoubtedly true when considered in light of some of the more notorious methods of interference which have been considered. Nevertheless, this pronouncement leaves the door open for the practitioner to "persuade" his patient to patronize a certain pharmacy through some more subtle method. Also, by allowing doctor ownership "provided there is no exploitation of the patient," the association has established a vague standard which lends itself to varying interpretations. When is a patient being exploited? Certainly it cannot be said that he is being exploited merely because his physician owns the pharmacy at which his prescription is filled. But neither can it be said that he is not being exploited because, in accordance with AMA safeguards, he happens to receive a copy of his prescription and seems to have a free choice of pharmacies. As with all ethical problems, a gray area exists which is difficult to define and

32 Statement of Phillip F. Jehle, *Associate General Counsel*, NARD, *Hearings*, 151. The actual text of this AMA statement is not available.

33 *Id.* at 151.

34 Statement of Dr. George A. Woodhouse, *Past Chairman, Judicial Council*, American Medical Ass'n, *Hearings*, 122-23.

35 AMA COUNCIL REPORTS, 50.

36 Compare text accompanying note 31, *supra*, with PRINCIPLES OF MEDICAL ETHICS, § 7 (1964) (as found in AMA COUNCIL REPORTS, VII).

37 AMA COUNCIL REPORTS, 5.

38 *Id.* at 6.

determine, and which becomes even more ambiguous when general ethical standards are applied.

The AMA's ambiguous position is even more puzzling when one considers its stand on other forms of patient exploitation which are comparable to the problem of physician ownership in pharmacies. For example, the basic principle that patient exploitation is contrary to the best interest of the public and the medical profession has led the AMA to flatly prohibit any physician ownership in a drug repackaging company,³⁹ and also to declare that it is unethical for a physician to have a financial interest in a pharmaceutical company "which he can control or does control while actively engaged in the practice of medicine."⁴⁰ It is inconsistent to say that it is unethical for a physician in Coffeyville, Kansas, to own one per cent of the stock in a drug repackaging company located in his area, but that it is entirely permissible for him to own a drugstore in his own community. The evils which the above provisions were intended to alleviate would seem to be closely analogous to the evils inherent in physician-owned pharmacies.

Inconsistencies also arise when the AMA's position on fee splitting is considered. The 1955 edition of the Principles of Medical Ethics stated: "Fee splitting violates the patient's trust that his physician will not exploit his dependence upon him and invites physicians to place the desire for profits above the opportunity to render appropriate medical service."⁴¹ Similarly, an opinion of the AMA house of delegates in 1947 said: ". . . [The] doctor may receive no profit other than payment for rendered medical services. Hence, it should be apparent that no rebate of any kind, in any form or from any source can be accepted. . . . They are, in every case, absolutely unethical."⁴²

The AMA has gone to great lengths to prohibit almost every conceivable form of fee splitting. To name a few instances, it has decreed that physicians who conduct a group practice and divide their income equally instead of according to the value of the services rendered by each are guilty of splitting fees.⁴³ Similarly, physicians who pay a certain percentage of their fees to a hospital for the utilization of its facilities are guilty of fee splitting.⁴⁴ It is submitted that physician ownership of a drugstore is just a sophisticated form of fee splitting. When a patient purchases a prescription, a charge is levied as the retail price of the drug, and a fee is added for the services of the pharmacist. Calling a part of the total amount charged "profit" and handing it over to the physician-owner does not change its basic character.

The inconsistencies do not cease here. The judicial council, in 1960, also decided that:

The rental of space by a physician or group of physicians as a pharmacy should be a fixed one. Were the rental to be based on the amount of business, *it might well be argued, and indeed be the case, that fee splitting*

39 *Id.* at 51.

40 *Ibid.*

41 PRINCIPLES OF MEDICAL ETHICS, ch. I, § 6 (1955).

42 AMA COUNCIL REPORTS, 45.

43 *Id.* at 46-47.

44 *Id.* at 47.

existed. In addition, the temptation would be ever present for the doctor-owner to encourage patients to take their prescriptions to that pharmacy. *The evils inherent in such practice are too obvious to be mentioned.*⁴⁵

Thus, the AMA is placed in the anomalous position of holding that for physicians to share in a percentage of the profits of a pharmacy, when such profits assume the form of rent, is unethical for reasons "too obvious to mention," but that physicians may own an entire pharmacy and take all of the profits without violating any ethical standards.

Surely doctor-owned pharmacies are contrary to the spirit, if not the letter, of these principles. The medical association of the state of Texas realized this and prohibited the physician from having an interest in a pharmacy.⁴⁶ However, 259 physicians in that state still own interests in some 117 pharmacies, largely because the practice has not been disapproved by the national body of the AMA.⁴⁷ Perhaps the reasons for the AMA's reluctance to condemn this practice lie more in politics than in ethics. There is a conflict of interest within the AMA as within all professional organizations. This is the conflict between its responsibilities to the public and its obligations to its own members.

3. The Codes of Ethics of the American Pharmaceutical Association and the National Association of Retail Druggists

All states require a registered pharmacist to be in charge of the drug-dispensing department of a drugstore. Therefore, before the physician can put his pharmacy into operation he must hire a registered pharmacist as an employee. Although prohibiting pharmacists from entering into such arrangements would be an effective way of doing away with the physician's pharmacy, neither the APhA nor the National Association of Retail Druggists⁴⁸ has attempted to do so. It is difficult to determine why these two organizations have not taken firmer steps. One reason for their hesitancy is probably the fact that their membership is not as vast as some other professional organizations, nor do they exercise the authority over professional matters typical of other professional organizations. Another factor can be found in the fact that there is no uniform code of ethics for the profession of pharmacy. Also, these organizations may be more interested in the larger problem of state legislation to restrict the ownership of pharmacies to registered pharmacists⁴⁹ and hence are not wasting much effort on the more particular problem of physician ownership.

However, the NARD and the APhA have been negotiating with the AMA

45 *Id.* at 50. (Emphasis added.)

46 THE ETHICAL CONSIDERATIONS OF PHYSICIAN OWNERSHIP OF PHARMACIES AND DRUG COMPANIES, paper presented by Dr. James H. Sammons, AMA Institute, Chicago, 1962, *Hearings*, 248-49.

47 Statement of Phillip F. Jehle, *Associate General Counsel*, NARD, *Hearings*, 158.

48 Hereinafter denoted in the text as NARD.

49 The NARD, for example, has adopted a resolution authorizing a study of ways to bring about the enactment of legislation to restrict the ownership of retail pharmacies to licensed pharmacists. Letter and mimeograph enclosure entitled, "Suggested Material to Effectuate Resolutions Adopted by NARD Conventions with Reference to — (A) Pharmacy Ownership Legislation, (B) Code of Ethics." From Herman S. Waller, General Counsel, NARD, to the NOTRE DAME LAWYER, March 24, 1965, on file in the office of the NOTRE DAME LAWYER.

since 1954 to do something about the doctor-owned drugstore.⁵⁰ A physician-pharmacist code of understanding has also been drafted and submitted to the AMA for approval. Section 7 of this Code states:

In the practice of medicine and in the practice of pharmacy a practitioner should limit the source of his professional income to professional services actually rendered by him, or under his supervision, to patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients.⁵¹

This code of understanding would appear to be an initial step in doing away with the problem although it does not expressly outlaw the practice. It is not inconceivable that the AMA would support a NARD-APhA effort to limit the ownership of drugstores to registered pharmacists and perhaps corporations which already have licenses. It is probable that a great many physicians who would agree that only a registered pharmacist should own a drugstore resent the suggestion that everyone except a physician should be allowed to own one. Negotiations between the representatives of the pharmacy profession and the AMA representatives on this subject would certainly seem to be desirable, and advantageous to both professions.

III. State Attempts at Regulation

A. *Liggett v. Baldrige*

It has long been recognized that the state has the power to regulate professions in the interest of public health, safety, and welfare. Accordingly, state and federal regulations strictly control the practice of pharmacy by setting standards for the quality of drugs and their proper dispensation. Presently, all states require that the drug departments of pharmacies be under the control of a registered pharmacist and that the dispensing be done by him or under his direct supervision. Such regulations have repeatedly been held constitutional as a valid exercise of the police power.⁵²

As to the specific problem of pharmacy ownership which is herein involved, state statutes which have attempted to prohibit anyone but a licensed pharmacist from owning a drugstore have been declared unconstitutional on the grounds that they are unreasonable and arbitrarily interfere with the nonpharmacist's constitutional right to participate in the business of his choosing. In *Liggett v. Baldrige*,⁵³ the United States Supreme Court invalidated such a Pennsylvania statute as violative of the equal protection and due process clauses of the fourteenth amendment. The stumbling block for this enactment was the Court's conception that the practice of pharmacy was more of a trade or occupation than a profession. The Court conceded that a state may regulate the practice

50 Statement of Dr. William S. Apple, *Executive Director*, APhA, *Hearings*, 200-03.

51 *Id.* at 201.

52 See cases collected in Annot., 74 A.L.R. 1084 (1931).

53 278 U.S. 105 (1928).

of pharmacy in matters which substantially relate to the public health and safety.⁵⁴ It also realized that "ownership carries with it a responsibility which does much to insure the proper practice of a profession when ownership is restricted to those qualified to practice,"⁵⁵ and that it was often not desirable to separate responsibility and control from the ownership of the business which resulted from a professional practice.⁵⁶ However, the Court concluded that the mere ownership of a drugstore "can have no real or substantial relation to the public health. . . ."⁵⁷

Joined in dissent by Mr. Justice Brandeis, Mr. Justice Holmes asserted:

Argument has not been supposed to be necessary in order to show that the divorce between the power of control and knowledge is an evil. The selling of drugs and poisons calls for knowledge in a high degree, and Pennsylvania after enacting a series of other safeguards has provided that in that matter the divorce shall not be allowed. . . . The Constitution does not make it a condition of preventive legislation that it should work a perfect cure. It is enough if the questioned act has a manifest tendency to cure or at least to make the evil less.⁵⁸

Following the *Liggett* decision, similar statutes in other states were likewise declared unconstitutional.⁵⁹ Since that 1928 opinion, however, the temper of the Supreme Court has changed and the scope of constitutional authority has broadened considerably. In the past thirty-seven years, state statutes which surely would have fallen had the judicial view of the *Liggett* Court survived, have been upheld. As the Court of Appeals of Maryland observed in a recent opinion, ". . . it [the *Liggett* case] has been seriously limited, if not completely undermined."⁶⁰ The devitalization of the doctrine of *Liggett v. Baldridge* has been followed in a few states by legislation restricting the ownership of pharmacies to registered pharmacists or prohibiting physicians from owning pharmacies. Whether these statutes will stand the test of constitutionality is still an open question.

B. Current State Law

At least five states have statutes dealing with or affecting physician owner-

⁵⁴ *Id.* at 111-12.

⁵⁵ *Id.* at 107.

⁵⁶ *Ibid.*

⁵⁷ *Id.* at 113.

⁵⁸ *Id.* at 114-15.

⁵⁹ *State v. People's Drug Stores*, 36 Del. 120, 172 Atl. 257 (Gen'l Sess. 1934); *Pratter v. Lascoff*, 261 N.Y. 509, 185 N.E. 716 (Per curiam), *cert. denied*, 289 U.S. 754 (1933).

⁶⁰ *Brooks v. State Bd. of Funeral Directors and Embalmers*, 233 Md. 98, 195 A.2d 728, 735 (1963). Many cases illustrate this change of attitude on the part of the Court. In *Daniel v. Family Security Life Ins. Co.*, 336 U.S. 220 (1949), the Court upheld a South Carolina statute which prohibited undertakers from serving as agents of life insurance companies for the sale of funeral insurance — a statute closely analogous to that considered in the *Liggett* case — as a valid exercise of the police power of the state. The Supreme Court also recently held that a Kansas statute making it a misdemeanor to engage in the business of debt adjusting except as incidental to the lawful practice of law did not violate the due process clause. *Ferguson v. Skrupa*, 372 U.S. 726 (1963).

ship of pharmacies.⁶¹ All of this legislation except the Michigan statute has been passed within the last five years.

The Michigan statute⁶² was enacted in 1927, one year before the *Liggett* decision, and it still remains the law of that state today. Since its passage, the statute has never been challenged. Its effect is to limit the right to own a pharmacy to registered pharmacists or corporations in which twenty-five percent or more of the stock is owned by licensed pharmacists. In a 1950 opinion the Attorney General of Michigan conceded that although this law would be declared unconstitutional according to the logic of the *Liggett* Court, it would be upheld today in either a state or federal court.⁶³

Although the high court of Michigan has never had the opportunity to decide the constitutionality of this particular statute, it has approved a somewhat similar statutory regulation affecting the practice of dentistry which made it a crime for a person other than a licensed dentist to own a dental parlor.⁶⁴

The North Dakota statute specifies that a permit to operate a pharmacy can be issued only if the applicant is a registered pharmacist or a member of a partnership in which each active member is a registered pharmacist, or a corporation or association in which the majority of stock is owned by registered pharmacists.⁶⁵ Like the Michigan law, this statute has never been tested.

The California enactment prohibits the pharmacy board from issuing new pharmacy permits to physicians and requires all physicians to rid themselves of any "membership, proprietary interest, or co-ownership" by June 1, 1967.⁶⁶ This law does not prevent other nonpharmacists from owning an interest in a pharmacy, nor does it prevent a doctor from leasing space in his building either under a straight rent or a percentage of the gross income.⁶⁷

This enactment differs from the Pennsylvania statute declared unconstitutional in the *Liggett* case in that it prohibits only physicians and surgeons from owning pharmacies. In considering the constitutionality of this exclusion, one might argue that the state legislature could reasonably conclude that it is in the public welfare to prohibit practitioners of medicine who prescribe medicines from having an interest in an establishment which fills prescriptions.

Both the Pennsylvania⁶⁸ and the Maryland⁶⁹ regulations in essence empower the state boards of pharmacy to suspend or revoke the license of a pharmacist for association as an employee, co-owner, or partner in any pharmacy in which a medical practitioner has an interest and declare such association to be unprofessional conduct.

The California, Maryland and Pennsylvania provisions can only be interpreted as an implicit recognition of the evils inherent in the physician-owned pharmacy, and represent an attempt on the part of those states to remedy the problem.

61 See statutes cited note 6 *supra*.

62 MICH. STAT. ANN. § 14.771 (1956).

63 OP. MICH. ATT'Y GEN. No. 1193 (April 5, 1950).

64 *People v. Carroll*, 274 Mich. 451, 264 N.W. 861 (1936).

65 N.D. CENT. CODE 43-15-35(5) (Supp. 1965).

66 CAL. BUS. & PROF. CODE § 654.

67 *Ibid.*

68 PA. STAT. ANN. tit. 63 § 390-5(9) (xii) (Supp. 1964).

69 MD. ANN. CODE art. 43, § 266A(c)(4)(iii) (Supp. 1964).

C. State Regulation of the Practice of Optometry

In conjunction with the problem of physician ownership of pharmacies, it is interesting to consider the present status of the law regulating the practice of the profession of optometry. The relationship between an optometrist⁷⁰ and the optician on the one hand, and the physician and the pharmacist on the other hand, is quite similar. Both the optometrist and the physician prescribe devices or medicines as treatment for the ills which they diagnose. These devices or medicines are ordinarily furnished by third parties. However, when the optometrist or physician himself becomes somehow involved in the furnishing of the prescribed articles, the danger of a sacrifice of medical competence and responsibility for the sake of profit from sales of medical supplies is ever present. It is this common danger to professional competence and integrity which makes an analysis of the regulation of the optical industry useful in discussing the physician-owned pharmacy problem. Admittedly the analogy is not perfect because ordinarily an optician hires an optometrist while the physician hires the pharmacist. However, in both cases, the evil of the mixture of professional obligation with the possibility of nonmedical commercial gain is present. Thus, a consideration of legislative regulation of the optical profession may shed some light on how to eliminate the evils of the physician-owned pharmacy.

There is a split of opinion among the states as to whether a corporation or a nonoptometrist may be allowed to hire an optometrist and sell his services to the public.⁷¹ The primary interest in this question focuses upon arrangements whereby opticians or optical companies hire a licensed optometrist and hold his services out to the public in the same or nearby premises. Certainly such arrangements place the seller of optical goods in a favored position to fill prescriptions issued by the licensed optometrist, and present the same problems raised earlier with relation to physician-owned pharmacies. Some states hold that any person or corporation may hire an optometrist and hold his services out to the public so long as the actual examining is done by the optometrist.⁷² Many of these states follow the *Liggett* rationale in holding that the identity of the employer of an optometrist can have no relation to the public health, safety, and welfare. In other states, statutes prohibiting a registered optometrist from becoming the servant of unregistered individuals or corporations have been held constitutional.⁷³ Courts in these states have held that such an arrangement permits the unlicensed party to exercise control over the professional activities of the licensed party, and that the separation of control and professional knowledge is an evil which is detrimental to the public interest.⁷⁴ Obviously, these courts recognize

70 An ophthalmologist is a physician who specializes in treating diseases of the eye; an optometrist examines the eye for defects and prescribes correctional lenses or exercises but not drugs or surgery; an optician grinds spectacle lenses to prescription and dispenses eyeglasses. WEBSTER'S SEVENTH NEW COLLEGIATE DICTIONARY (1963).

71 See cases collected in Annot., 128 A.L.R. 585 (1940).

72 *People v. Sterling Optical Co.*, 26 Misc.2d 412, 209 N.Y.S.2d 953 (Sup. Ct. 1960), *aff'd mem.*, 11 N.Y.2d 970, 229 N.Y.S.2d 419, 183 N.E.2d 698 (1962).

73 *Williamson v. Lee Optical Co.*, 348 U.S. 483, 491 (1954); *Kay Jewelry v. Board of Registration in Optometry*, 305 Mass. 581, 27 N.E.2d 1 (1940); *McMurdo v. Getter*, 298 Mass. 363, 10 N.E.2d 139 (1937).

74 *McMurdo v. Getter*, *supra* note 73, at 142; *Ezell v. Ritholz*, 188 S.C. 39, 198 S.E. 419 (1938).

that it would be beneficial to the public welfare if optometrists were not subject to the control of unlicensed, unprofessional persons. As the Supreme Court of South Carolina said in *Ezell v. Ritholz*:⁷⁵

The ethics of any profession is [sic] based upon personal or individual responsibility. One who practices a profession is responsible directly to his patient or his client. Hence, he cannot properly act in the practice of his vocation as an agent of a corporation or business partnership whose interests in the very nature of the case are commercial in character.⁷⁶

In holding that the state of Pennsylvania could prohibit a corporation from practicing optometry through hired licensed optometrists, the United States Supreme Court, in *Neill v. Gimbel Bros.*,⁷⁷ stated:

One who practices a profession is apt to have less regard for professional ethics and to be less amenable to regulations for their enforcement when he has no contractual obligations to the client, does not fix or receive the fees, and is under the control of an employer whose commercial interest is in the volume of sales of merchandise affected by the prescriptions of the employee-practitioner.⁷⁸

In short, these courts have realized that when a professional practitioner such as an optometrist is subjected to the control of an unprofessional employer and is dependent upon him for compensation, it is possible that "the welfare of the patient would not be the sole criterion applied by the optometrist in rendering services to him."⁷⁹ Of special significance to the problem at hand is the statement of some courts that the practicing optometrist should have no interest whatever in the establishment which fills his prescriptions.⁸⁰

No cases have been found dealing with the specific problem of the ownership of an optical dispensing shop by an ophthalmologist or an optometrist. The AMA's stand on this practice is the same as its position on physician ownership of pharmacies, *i.e.*, the practice is not improper provided there is "no exploitation of the patient."⁸¹ The AMA also holds that an ophthalmologist may lease space to an optician on a fixed rental basis in a medical building owned by the ophthalmologist so long as patients are not "steered" to the optician.⁸²

Prime targets for state legislation have been arrangements between optometrists or ophthalmologists and opticians or optical companies in which the prescribing practitioner is given a kickback or rebate of a percentage of the cost of the prescribed optical products as a reward for patient referral.⁸³ Of course, these fee-splitting arrangements are readily comparable to similar agreements between physicians and pharmacists, and they have been declared "absolutely

75 188 S.C. 39, 198 S.E. 419 (1938).

76 *Id.* at 424.

77 330 Pa. 213, 199 Atl. 178 (1938).

78 *Id.* at 182.

79 *Lieberman v. Connecticut St. Bd. of Examiners in Optometry*, 130 Conn. 344, 34 A.2d 213 (1943).

80 *Rowe v. Burt's, Inc.*, 31 N.E.2d 725, 727 (Ohio Ct. App. 1939). See also *Neill v. Gimbel Bros.*, 330 Pa. 213, 199 Atl. 178 (1938).

81 AMA COUNCIL REPORTS, 51.

82 *Id.* at 52.

83 *E.g.*, MINN. STAT. ANN. § 148.57(3) (1946); OKLA. STAT. ANN. tit. 59, § 944 (1963).

unethical" by the AMA⁸⁴ and have also been forbidden by law in many states.⁸⁵ In spite of these barriers, this practice became so widespread that the Federal Trade Commission attempted to eliminate fee-splitting arrangements by regulating the optical products industry.⁸⁶ The antitrust aspects of the problem of physician ownership can best be understood by considering these regulations.

IV. Federal Regulation of the Optical Products Industry

In 1948, the Department of Justice initiated six separate class actions against approximately 4,000 doctors who were discovered sharing profits connected with the sale of optical products. In *United States v. American Optical Co.*,⁸⁷ action was brought against an optical association, a corporation, and several physicians and individuals, the latter as representatives of a class of some 2,000 oculists. The Government charged that the defendants had conspired to influence patients of the doctors to have their prescriptions filled by the optical association's members, and that the latter added extra charges for fitting fees and rebates to the physicians (usually one-half of the consumer price) to the prevailing consumer rates, thereby restraining interstate trade in violation of the Sherman Anti-Trust Act. Defendants in the *American* case and the other five actions submitted to a consent decree, whereupon the court enjoined the defendant doctors from accepting, directly or indirectly, payments of any type from any dispenser of optical goods, whether such dispenser acts as the agent of the doctor or otherwise, and also enjoined the doctors from entering into any agreement or plan whereby they would receive payments from any dispenser.⁸⁸

These "Optical Rebating Cases" prompted the FTC to promulgate rules for the optical products industry.⁸⁹ Section 192.7(b) of those rules, which is very similar to the court's decree in the *American Optical* case, declares:

It is an unfair trade practice for any dispenser to make or give directly or indirectly, to any doctor (whether such dispenser acts or purports to act as an agent of the doctor or otherwise), any payment arising out of or connected with his (the dispenser's) sale or dispensing of eyeglasses or contact lenses to a patient of such doctor, whether such payment be in the form of, or is described or regarded as, a rebate, credit, credit balance, gift, dividend, participation in or share in profits, or otherwise; or for a dispenser to enter into or participate in any agreement, understanding, scheme, plan, or concert of action, with any doctor, or with any other party or parties, which provides for, or facilitates, any such payments.⁹⁰

These rules also prohibit the physician from tying in or conditioning an eye examination with the purchase of eyeglasses or contact lenses he may prescribe, where there is a danger that such practice would substantially injure competi-

84 AMA COUNCIL REPORTS, 45.

85 See, e.g., statutes cited note 83 *supra*.

86 16 C.F.R. §§ 190.0-192.21 (Supp. 1965).

87 97 F.Supp. 66 (N.D. Ill. 1951).

88 Letters from Department of Justice to various doctors in response to inquiries concerning the rules, as cited in Appendix to 16 C.F.R. §§ 192.0-192.21 (Supp. 1965).

89 16 C.F.R. §§ 192.0-192.21 (Supp. 1965).

90 16 C.F.R. § 192.7(b) (Supp. 1965).

tion, "or create or tend to create a monopoly, at any competitive level in the trade area or areas where the practice is employed."⁹¹ However, the doctor is nevertheless permitted by the rules to dispense eyeglasses or contact lenses in his own professional offices either by himself or through an employee.⁹²

The decisions in the "Optical Rebating Cases" and the FTC rules discussed above were intended to eliminate fee-splitting practices. However, it is almost certain that both would also prohibit a doctor from owning an interest in an optical company engaged in dispensing. In the opinion of the Department of Justice, stock investments by doctors in an optical company to which they direct their patients and from which they receive dividends would be in violation of the "Optical Rebating Judgments."⁹³ The fact that the doctor owns all of the optical dispensing establishment and receives all of the profits rather than stock dividends would seem only to compound the violation.

From the antitrust standpoint, there is very little difference between a physician partaking in the profits from the sale of prescription eyeglasses or from the sale of prescription drugs. If the FTC found it in the public interest to prohibit all forms of payments between optical dispensers and doctors—even to the point of prohibiting doctors from owning optical dispensing establishments—might it not also be in the public interest to prohibit all payments between pharmacists and physicians—even to the point of prohibiting doctor ownership of pharmacies? It is submitted that the same factors which prompted the FTC to take steps to strictly regulate the former are no less present in the latter circumstances. However, before government regulation of physician-pharmacist relationships can be considered, it will be necessary to consider the applicability of the antitrust laws to the problem.

V. Possible Regulation of Physician Ownership in Pharmacies Under the Federal Trade Commission Act

It is generally recognized that the purpose of the antitrust laws is to foster free competition by prohibiting agreements or arrangements which tend to hinder competition, create monopolies, or restrain trade. The basic theory behind these laws is that many independent enterprises competing with one another will afford the greatest stimulation to the economy and produce the best in quality and service at the most reasonable cost.

The independent pharmacist is a competitor in an area of economic activity in which the demand for his products and services is ultimately exercised not by the consumer, but by the prescribing doctor. The doctor ideally is not his competitor, but rather is a source of some of his prescription business. A physician entering the drug prescription market in competition with a pharmacist enjoys many obvious advantages, as have been previously discussed.⁹⁴ Plainly, if a sufficient number of physicians purchased their own pharmacies and "per-

91 16 C.F.R. § 192.7(c) (Supp. 1965).

92 Letters From Department of Justice to various doctors in response to inquiries concerning the rules, as cited in Appendix to, 16 C.F.R. §§ 192.0-192.21 (Supp. 1965).

93 *Ibid.*

94 See text accompanying notes 22-23 *supra*.

suaded" their patients to patronize their establishments, some independent pharmacists would be driven out of business and free competition would suffer. Hence, there is a real danger that if this practice is not regulated by some means or other, the spirit of the antitrust laws will be frustrated.

The antitrust laws may be used only to regulate commercial activities which take place in interstate or foreign commerce. It has been consistently held that the prescription drug is an article of interstate commerce and therefore subject to federal regulation.⁹⁵ Although the pharmacist does perform a professional service, the sale of the drug itself is an "entrepreneurial" rather than a professional activity.⁹⁶ A distinction must be made between matters affecting the practice of professions and matters of trade or commerce. Professional services are essentially local in nature, and the fact that the pharmacist uses commodities which have traveled in interstate commerce does not justify interference with professional services.⁹⁷ However, if the professional service can be separated from the commercial transaction which accompanies it, the latter may be regulated without interference with the former. For example, the Food, Drug, and Cosmetic Act⁹⁸ has successfully regulated commodities in commerce without affecting the practice of any profession. Similarly, the antitrust laws do not prevent physicians from combining to fix fees for professional services, since such services are not commodities or merchandise in interstate commerce.⁹⁹ The profession of pharmacy has greatly affected mass production and modern sales methods, and consequently, a very small percentage of the prescription drugs sold today require some added "service" such as compounding before they are passed on to the consumer.¹⁰⁰ In a very real sense, the pharmacist merely acts as a "conduit" to deliver the drugs from the flow of interstate commerce to the purchaser,¹⁰¹ and thus seems to be more of a tradesman than a professional.

Thus, merely because prescription drugs are handled by a professional pharmacist before they are sold to the consumer does not place them beyond antitrust regulation. Courts have shown a willingness to strike down agreements between pharmacists which unlawfully restrict free competition in interstate trade. For example, agreements between pharmacists to fix the prices of drugs as distinguished from fees for services have been struck down as violative of the Sherman Act.¹⁰² In one such case, *Northern California Pharmaceutical Ass'n v. United States*,¹⁰³ the Ninth Circuit explained: "We do not decide that every

95 *Northern Cal. Pharmaceutical Ass'n v. United States*, 306 F.2d 379, 384 (9th Cir.), cert. denied, 371 U.S. 862 (1962); *United States v. Utah Pharmaceutical Ass'n*, 201 F.Supp. 29, 33 (D. Utah), aff'd 371 U.S. 24 (1962). Cf. *Dr. Miles Medical Co. v. John D. Park & Sons Co.*, 220 U.S. 373 (1911).

96 *Northern Cal. Pharmaceutical Ass'n*, supra note 95, at 385.

97 See, e.g., *Spears Free Clinic v. Cleere*, 197 F.2d 125, 126 (10th Cir. 1952).

98 52 Stat. 1040 (1938), 21 U.S.C. §§ 301-517 (1964).

99 *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah) (dictum), aff'd, 371 U.S. 24 (1962); *Rohlf v. Kasemeier*, 140 Iowa 182, 118 N.W. 276 (1908).

100 *United States v. Utah Pharmaceutical Ass'n*, supra note 99, at 33 (setting the figure at about 10%).

101 *Id.* at 33.

102 *Northern Cal. Pharmaceutical Ass'n v. United States*, 306 F.2d 379 (9th Cir.), cert. denied, 371 U.S. 862 (1962); *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah), aff'd, 371 U.S. 24 (1962).

103 *Northern Cal. Pharmaceutical Ass'n v. United States*, supra note 102.

action of professionals is within the reach of the Sherman Act. We do decide that an agreement among professionals to fix a commodity price is."¹⁰⁴

Another question which must be considered in determining the applicability of the antitrust laws to the present problem is whether the flow of interstate commerce ceases when the prescription drug reaches the pharmacist's shelf, thus making the sale to the consumer a wholly intrastate transaction. In the *Northern California Pharmaceutical Ass'n* case, the court held that such a sale took place in interstate rather than intrastate commerce.¹⁰⁵ The court viewed "interstate commerce" as a practical business concept which should not be the subject of technical distinctions and found a "practical continuity of movement" from the manufacturer to the consumer since "the undivided attention of manufacturer, warehouseman, wholesaler and retailer is upon the ultimate consumer and his immediate aides, the physician and pharmacist. . . ."¹⁰⁶

It is clear then, that the pharmacist is no less subject to regulation under the antitrust laws than any other retailer of commodities which have traveled in interstate commerce and that pharmacists who monopolize, use unfair methods of competition, or who in other ways restrain trade or commerce violate the antitrust laws. Similarly, physicians who purchase their own pharmacies and "steer" their patients to these establishments hinder free competition between their pharmacies and those owned by others. There would be no possibility of antitrust violation if the methods used were completely fair. However, any physician who carries on such practices is *per se* engaged in an unfair method of competition vis-à-vis owners of competing pharmacies, because of his unique ability to capitalize on the trust which his patient places in him.

To repeat, it is probably true that the majority of physicians who own pharmacies do not use such unfair methods, *i.e.*, steering patients to their pharmacies. However, if present trends of physician ownership continue, the number of unscrupulous physician-owners would correspondingly increase and this very possibly could result in substantial interference with free competition. Since it is extremely difficult to pinpoint and control some of the more subtle methods the owner-physician may use to steer patients to his pharmacy, any attempt at regulation under the antitrust laws short of outright prohibition of such ownership would be fraught with difficulties. It is submitted that rules similar to those established by the FTC to regulate the optical products industry would be the most efficacious antitrust solution to the problem.

Section 5 of the Federal Trade Commission Act, the ultimate basis of the optical products industry regulations, declares "unfair methods of competition" and "unfair or deceptive acts in commerce" unlawful.¹⁰⁷ This section is supplementary to the Sherman and Clayton antitrust acts¹⁰⁸ and authorizes the Commission to issue cease and desist orders when it is proven that a substantial amount of present or potential competition is injured or threatened with injury

104 *Id.* at 386.

105 *Id.* at 387.

106 *Ibid.*

107 38 Stat. 719 (1914), 15 U.S.C. § 45 (1964).

108 *FTC v. Raladam Co.*, 283 U.S. 643, 647 (1931).

because of the use of unfair competitive methods.¹⁰⁹ Just what constitutes "unfair methods of competition" is left without definition. "Congress deemed it better to leave the subject without precise definition, and to have each case determined upon its own facts, owing to the multifarious means by which it is sought to effectuate such schemes."¹¹⁰ Before the Commission can issue cease and desist orders or promulgate rules affecting a particular industry or trade it must be determined: (1) that the methods complained of are unfair; (2) that the methods are used in competition in commerce; and (3) that action by the Commission will be in the interest of the public.¹¹¹ As to the latter requirement, the Court in *FTC v. Klesner*¹¹² explained:

To justify filing a complaint the public interest must be specific and substantial. Often it is so, because the unfair method employed threatens the existence of present or potential competition. Sometimes, because the unfair method is being employed under circumstances which involve flagrant oppression of the weak by the strong. Sometimes, because, although the aggregate of the loss entailed may be so serious and widespread as to make the matter one of public consequence, no private suit would be brought to stop the unfair conduct, since the loss to each of the individuals affected is too small to warrant it.¹¹³

It is submitted that the same considerations which prompted the FTC to prohibit dispensers of optical products from making payments in any form to the physician who prescribes their products—a prohibition which presumably extends to prohibit the physician from sharing in the profits of an optical dispensing company owned by him—are also present in the situation here under discussion. Certainly, all of the prerequisites for FTC action exist. First, any method used by the physician-owner to influence his patient to patronize his pharmacy would have to be considered an unfair method of competition; the physician is taking wrongful advantage of the confidence and trust the patient places in him, and of his power to create the demand for the very commodities which his own pharmacy sells. Second, the sale of a prescription drug is a transaction in interstate commerce,¹¹⁴ and any unfair methods used in connection with such sales would appear to be susceptible to antitrust regulation. Third, the public will best be served if medical patients have a completely free choice of pharmacies. The competition brought about by free choice of pharmacies will necessarily result in better services at a lower cost to the consumer-patient and to the general public.

However, any consideration of possible antitrust regulation in this area must take into account the problem of the extent of the practices to be prohibited. This problem of extent may prove to be the major stumbling block to regulation in the present situation. The antitrust laws are most readily applied if the interference with interstate commerce is direct, intentional, and substantial rather

109 *Id.* at 651; 38 Stat. 719 (1914), 15 U.S.C. § 45(b) (1964).

110 *FTC v. Beech-Nut Co.*, 257 U.S. 441, 453 (1922).

111 *FTC v. Raladam Co.*, 283 U.S. 643, 646-47 (1931); *FTC v. Klesner*, 280 U.S. 19, 28 (1929).

112 *FTC v. Klesner*, *supra* note 111.

113 *Id.* at 28.

114 See text accompanying note 95 *supra*.

than indirect, unintentional, and remote.¹¹⁵ Traditionally, courts will not find violations of the antitrust laws unless a substantial amount of interstate commerce is affected by the restraints on competition complained of.¹¹⁶ The degree of injury may not be "so insignificant as to call for the application of the maxim, 'de minimis non curat lex.'"¹¹⁷

The "de minimis" rule would appear to be the principal barrier in the way of effective government regulation through the antitrust laws. The undesirable effects of physician ownership result from the actions of many physicians acting independently of one another. There is no conspiracy among these owners to monopolize the prescription business. The interference with interstate commerce which results when one physician uses unfair methods of competition to monopolize his own prescription trade is so insignificant when compared to the entire market as to certainly fall within the "de minimis" rule. Even a clinical pharmacy which has a monopoly over the prescriptions of a large number of doctors would fall within the rule because it is doubtful that the arrangement would ever reach the size which would enable it to substantially interfere with interstate commerce.

Moreover, even if the "de minimis" rule were not a barrier to regulation, to bring suit against all of these physicians individually would be an impossible task. The government would be required to file separate actions against each. All could not be joined as class defendants because they act independently and there is no common bond of illegality uniting them. The government was able to successfully prosecute the "Optical Rebating Cases" by filing separate actions against six large optical companies, and joining as class defendants in each case the physicians who were receiving payments from these respective companies. The suit against the American Optical Company, for example, alleged that the company and approximately 2,000 doctors participated in concerted activity in violation of the antitrust laws.¹¹⁸

Thus, it must be concluded that it is highly improbable that the government could or would proceed against physicians who own pharmacies and practice unfair methods of competition under the existing antitrust legislation. Assuming, *arguendo*, that such practices are in violation of these laws, their effect, when taken on an individual basis, would seem too insubstantial to warrant — or allow — government interference. Thus, before the government could attempt to eliminate these practices, new federal legislation would be necessary.¹¹⁹

115 *Levering & Garriques Co. v. Morrin*, 289 U.S. 103, 107 (1933); *Spears Free Clinic v. Cleere*, 197 F.2d 125, 127 (10th Cir. 1952).

116 *Ibid.* See also *Apex Hosiery Co. v. Leader*, 310 U.S. 469, 510 (1940); *Industrial Ass'n of San Francisco v. United States*, 268 U.S. 64, 80-82 (1925); *Hopkins v. United States*, 171 U.S. 578, 592 (1898).

117 *Industrial Ass'n of San Francisco v. United States*, *supra* note 116, at 84. See *Glenn Coal Co. v. Dickinson Fuel Co.*, 72 F.2d 885, 889 (4th Cir. 1934); *G. D. Searle & Co. v. Institutional Drug Distribs.*, 151 F. Supp. 715, 724 (S.D. Cal. 1957).

118 *United States v. American Optical Co.*, 97 F. Supp. 66, 67 (N.D. Ill. 1951).

119 Senator Phillip A. Hart, Chairman of the Subcommittee on Antitrust and Monopoly, and the main proponent of federal regulation of physician-owned pharmacies, recently announced that he would sponsor a bill which would prevent doctors from making any profit on the sale of medicines they prescribe for patients. The bill will also apply to ophthalmologists who sell eyeglasses. *South Bend Tribune*, Sept. 27, 1965, p. 2, col. 4.

VI. Conclusion

Due consideration of the present and potential dangers to free competition and the subsistence of the independent pharmacist inherent in physician ownership of pharmacies, compels the conclusion that there is but one effective means to permanently eliminate these harmful effects — outright prohibition of physician ownership. There are three feasible methods for accomplishing this end. The first is through restrictions imposed by the federal government — a procedure which would probably require new federal legislation. The second is through prohibitory legislation passed by the individual state legislatures. The third would require condemnation of this practice within the professions themselves. Of the three approaches, the last would certainly seem to be the most efficacious. Any attempts at legislative prohibition would surely be opposed by powerful lobbying interests. Moreover, such legislation would ultimately have to withstand the test of constitutionality. Clearly, the simplest and most conclusive means would be self-regulation by both the medical and pharmaceutical professions. The problem is first and foremost, an ethical one.

Ideally, pharmacists should be free to manage and control their own professional practices. Ideally, physicians and pharmacists should operate independently of one another for the welfare of the patient. Ideally, professionals should administer to the public with a spirit and dedication above the “morals of the market place” and should put their professional obligations before their desires for personal financial gain. Ideally, professions should require of their members responsibilities and moral standards which are above the minimal requirements of the law and should be capable of regulating the conduct of their members without the necessity of outside interference. Unfortunately, not all of these ideals have become reality. However, this is not a repudiation of their strength or validity; they remain principles for which every physician, pharmacist and their representative professional organizations should strive.

Physicians rightly resent the implication that they cannot be trusted to own pharmacies and operate them without exploiting the public while the ordinary businessman can. However, some practices may be demoralizing to the medical profession and shake the public confidence even though they are not prohibited by law and in spite of the fact that the doctors engaged in these practices maintain the highest professional standards. In these situations, the physician has the added duty — not only to the public, but also to his own profession — of avoiding the appearance of evil for the sake of professional honor and integrity. The ownership of a pharmacy by a physician is precisely the kind of situation in which the appearance of evil should be avoided. The practice is contrary to the entire spirit if not the letter of the Principles of Medical Ethics. As we have seen, these principles presently provide that: (1) “physicians should recognize and promote the practice of pharmacy as a profession”;¹²⁰ (2) “a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients”;¹²¹ (3) it

¹²⁰ PRINCIPLES OF MEDICAL ETHICS, ch. VIII, § 3 (1955).

¹²¹ PRINCIPLES OF MEDICAL ETHICS, § 7 (1964) as found in AMA COUNCIL REPORTS, VII).

is unethical for a physician to receive a "kickback, rebate, loan, favor, or emolument" with or without the knowledge of the patient for the referral of the patient to another physician;¹²² (4) "the acceptance of rebates on prescriptions and appliances or of commissions from those who aid in the care of patients is unethical";¹²³ (5) sharing in the profits of a pharmacy through a rental based on a percentage of the gross income is unethical.¹²⁴

Thus, the problem for the physician is one of compliance with the spirit of these ethical principles and a readiness to forego the right to own a pharmacy for the good of the profession. A further burden of leadership falls upon the AMA to declare physician-owned pharmacies inconsistent with the Principles of Medical Ethics and to resolve this inconsistency.

The profession of pharmacy has a similar obligation in this area. Before pharmacy can hope to attain full professional status, it must take greater responsibility for the actions of pharmacists and exercise more control over its members. Without a registered pharmacist to dispense the drugs, the physician could not operate a pharmacy. Presently, pharmacy strongly supports state laws which would allow only registered pharmacists to own a pharmacy. It hopes to free the profession from the unfortunate aura of variety store commercialism which oftentimes surrounds it and accord to it the dignity which it should have. It is submitted that an ethic prohibiting pharmacists from practicing in pharmacies wholly or partially owned by physicians would be an important step in this direction and would eliminate a practice which is detrimental to both professions.

Martin F. Idzik

122 PRINCIPLES OF MEDICAL ETHICS, ch. I, § 6 (1955).

123 PRINCIPLES OF MEDICAL ETHICS, ch. I, § 9 (1955).

124 AMA COUNCIL REPORTS, 50.